NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC GOODS POOLS

FREESTANDING CLINICAL LABORATORY
CERTIFICATION FORM

For the Month of _____, _____

PROVIDER NAME: _____

ADDRESS: _____

FEDERAL TAX ID #: _____

PERMANENT FACILITY IDENTIFIER (PFI#): _____

COMPLETED BY: _____

TITLE: _____

TELEPHONE: _____

CONSOLIDATED REPORT:
Check the box below, if applicable:

[ ] **This Certification and the attached report represent a consolidated reporting submission for all of the entities listed on Attachment 1 of this Certification form.**

CERTIFICATION

I, _____, CERTIFY THAT I AM THE CHIEF EXECUTIVE/FINANCIAL OFFICER AND/OR ADMINISTRATOR OF THE ABOVE MENTIONED ORGANIZATION, AND FURTHER CERTIFY TO ALL OF THE FOLLOWING:

- THAT THE DATA BEING PROVIDED HAS BEEN CAREFULLY PREPARED FROM THE BOOKS AND RECORDS WITHIN THIS ORGANIZATION IN ACCORDANCE WITH THE INSTRUCTIONS CONTAINED HEREIN, INCLUDING BUT NOT LIMITED TO THE PROPER SEGREGATION OF INFORMATION BY SERVICE YEAR AND THAT ALL SECTIONS AND REQUIRED SERVICE YEAR PORTIONS OF THE REPORT HAVE BEEN COMPLETED AND SUBMITTED AND,

- TO THE BEST OF MY KNOWLEDGE, I BELIEVE THE INFORMATION PRESENTED HEREIN IS ACCURATE AND CORRECT.

SIGNATURE: _____

DATE: _____

TYPE/PRINT NAME: _____

TITLE: _____

FREESTANDING CLINICAL LABORATORY
CERTIFICATION (Con't)

Summary of Consolidated Report Submission

For the Month of _____, _____

Provider Name: _____ **PFI#:** _____
Contact: _____ **Telephone #:** _____

If the Certification form and attached report form represent a consolidated reporting submission, enter the name and Permanent Facility Identifier Number (PFI#) of each entity included in the reporting submission.

Provider Name	PFI#